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Rashed, Mohammed Abouelleil (2020) The identity of psychiatry and the challenge of mad activism: rethinking the clinical encounter. *Journal of Medicine and Philosophy* 45 (6), pp. 598-622. ISSN 0360-5310.

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The Identity of Psychiatry and the Challenge of Mad Activism: Rethinking the Clinical Encounter

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Central to the identity of modern medical specialities, including psychiatry, is the notion of hypostatic abstraction: doctors treat conditions or disorders, which are conceived of as “things” that people “have.” Mad activism rejects this notion and hence challenges psychiatry’s identity as a medical speciality. This article elaborates the challenge of Mad activism and develops the hypostatic abstraction as applied to medicine. For psychiatry to maintain its identity as a medical speciality while accommodating the challenge of Mad activism, it must develop an additional conception of the clinical encounter. Toward elaborating this conception, this article raises two basic framing questions: For what kind of understanding of the situation should the clinical encounter aim? What is the therapeutic aim of the encounter as a whole? It proposes that the concepts of “secondary insight” (as the aim of understanding) and of “identity-making” (as a therapeutic aim) can allow the clinical encounter to proceed in a way that accommodates the challenge of Mad activism.

Keywords: *clinical encounter, hypostatic abstraction, identity-making, Mad activism, Mad Pride, madness, mental health activism, primary insight, secondary insight, symptom control*

I. INTRODUCTION

Psychiatry has an identity in the sense that it is constituted by certain understandings of what it is and for what it is. The key element in this identity is that psychiatry is a medical speciality. During the early years of their training,

medical doctors make a choice about the specialty they want to pursue.¹ Psychiatry is one of them, and so is ophthalmology, cardiology, gynecology, and pediatrics. Modern medical specialties share some fundamental features: they treat conditions, disorders, or diseases; they aspire to be evidence-based in the care and treatments they offer; they are grounded in basic sciences such as physiology, anatomy, histology, and biochemistry; and they employ technology in investigations, research, and development of treatments. These features characterize modern medical specialties even as physicians are increasingly framing their work in ways that take account of the whole person, recognizing conflicting values and their implications for diagnosis and treatment, and acknowledging the role of the arts and humanities in medical education and practice (see, e.g., McManus, 1995; Cox, Campbell, and Fulford, 2007; Cook, 2010; Fulford, van Staden, and Crisp, 2013).

Psychiatry differentiates itself from other medical specialties by the conditions that it treats: *mental* health conditions or disorders, to be contrasted with *physical* health conditions or disorders. The nature of its subject matter, which is disturbances of the mind and their implications, raises certain complexities for psychiatry that, in the extreme, are sometimes taken to suggest that psychiatry's positioning as a medical specialty is suspect; these include the normative nature of psychiatric judgments, the explanatory limitations of psychiatric theories, and the classificatory inaccuracies that beset the discipline. There are significant, ongoing debates in these three areas that do not, at present, appear to be nearing resolution.² Now these debates are themselves superseded by a foundational challenge to psychiatry's identity as a medical specialty, a challenge that emanates from particular approaches in mental health activism.³ These approaches, which I refer to as Mad activism, reject the language of "mental illness" and "mental disorder," and with it the assumption that people have a condition that requires treatment. The idea that medicine treats conditions, disorders, or diseases is at the heart of medical practice and theory, and this includes psychiatry insofar as it wishes to understand itself as a branch of medicine. In rejecting the premise that people "have" a "condition," Mad activism is issuing a challenge to psychiatry's identity as a medical specialty.

In this article, I examine how psychiatry might accommodate the challenge of Mad activism in the context of the clinical encounter. In Section II, I clarify this challenge and situate it in relation to other approaches in mental health activism. In Section III, I unpack what is involved in the challenge through a discussion of the concept of the "hypostatic abstraction," a logical and semantic operation first identified by the philosopher Charles Sanders Peirce. I argue that, insofar as the condition is posited as some *thing* to be managed and treated, the hypostatic abstraction lies at the heart of medical practice and theory. The challenge of Mad activism to psychiatry consists in its rejection of the hypostatic abstraction. In Section IV, I outline some responses to this challenge. If psychiatry wishes to

maintain its identity as a medical specialty while also accommodating the challenge of Mad activism, it must develop an additional conception of the clinical encounter in order to be able to work with individuals who consider themselves to have a condition as well as those who reject the hypostatic abstraction. Towards elaborating this conception, I raise two fundamental questions that frame the clinical encounter: For what kind of *understanding* of the situation should the clinical encounter aim? What is the *therapeutic aim* of the encounter as a whole? These questions are addressed in sections V and VI, respectively. I propose that the concepts of “secondary insight” (as the aim of understanding) and of “identity-making” (as a therapeutic aim) can allow the clinical encounter to proceed in a way that accommodates the challenge of Mad activism.

II. THE CHALLENGE OF MAD ACTIVISM

Dissatisfaction with the treatment of individuals considered to be “mad,” “insane,” or “mentally ill” goes back a long way, but the 1970s are regarded as the starting point of a distinctive wave of activism that persists to this day.⁴ In the wake of the efforts of black, gay, and women’s civil rights movements, a number of connected mental health movements began organizing for the civil rights of users and survivors of psychiatric treatment and for reform of mental health institutions. In time, the mental health consumer/survivor/ex-patient (c/s/x) movements grew and diversified, and today various discourses and initiatives can be identified: in addition to long-standing concerns with coercive interventions, lack of involvement in recovery, limited access to treatment, and social stigma, some activists have rejected the medicalization of madness. This latter concern is reflected in aspects of Mad Pride and mad-positive activism, which I refer to in what follows as Mad activism.⁵

A key difference between Mad activism and treatment-focused endeavors is the former’s formulation of the problem in terms of respect and recognition. What is at stake is the way in which people’s identities are publicly represented and valued, with the dominant view of madness as a disorder of the mind being seen as an affront to a positive identity. The goal is not only to reform psychiatry, but to effect cultural change in the way madness is viewed. As [Schrader, Jones, and Shattell \(2013, 62\)](#) write, activists “have moved beyond treatment-centered activism to articulate a broader culture of madness.” In this respect, the aims of Mad activism overlap with those of other movements that organize around issues of identity and recognition. In the domain of sexual orientation and gender, for example, gay rights and trans rights are not only concerned with countering discrimination in employment opportunities, but with achieving symbolic and cultural reparation in society.

Mad activism, therefore, is a distinctive approach within the broader mental health activism. Activists are rejecting the language of “mental illness” and “mental disorder,” reclaiming the term “mad,” and presenting madness as grounds for identity. These quotes exemplify this position:

Madness is an aspect of my identity—who I am and how I experience the world—not an “illness” that is separate from me or a collection of “symptoms” I want cured. (Triest, 2012, 20–21)

Mad Pride moves away from medicalizing experiences under psychiatry to promote other sorts of framings. These Mad positive approaches do not pathologize me. Instead of being seen as someone who is “sick,” I am seen as someone who diverges from our traditional narrow, exclusive, and discriminatory idea of “normal.” I need the world to be different so that I can thrive as the person that I am . . . Mad Pride sees Mad people as a people and equity-seeking group similar to other marginalized populations. We are not just “individuals” with “illness.” (deBie, 2013, 7)

The claims and demands of Mad activism raise many questions. For example, can madness really be grounds for identity as activists claim? And what about the distress and disability that are a feature of mental health conditions—how can these be reconciled with a positive framing of these conditions? And with regard to the demands of Mad activism, what moral and political justifications can support them, and what are the appropriate social and political responses to them? All of these are important questions to which I attend elsewhere (Rashed, 2019b, 2019a).

In this article, I want to focus on one key issue, which is activists’ rejection of the idea that they have a condition that requires treatment. Can psychiatry accommodate this claim? This question is not confined to activism because it reaches to the heart of the clinical encounter: compared to other medical specialties, psychiatrists often find themselves assessing individuals who do not consider themselves to have a condition that requires treatment. It could be argued that it does not matter what the patient thinks in this regard; if he has a mental disorder and lacks insight into the nature of his condition, and if he satisfies the legal criteria for detention, including the presence of risk to self and/or others, then there are grounds for involuntary detention. While this is how the situation tends to proceed in practice, what I want to ask is how it can proceed if we regard the person’s rejection of the idea that he has a condition as a non-negotiable starting point. Is the clinical (psychiatric) encounter conceptually equipped to deal with this situation?²⁶ As I argue in what follows, psychiatry, as a body of knowledge and as a set of institutional practices, lacks the conceptual resources to handle this situation and accommodate the person’s view (notwithstanding individual clinician’s experience and wisdom in doing so). A key reason why this is so is that psychiatry’s positioning as a medical specialty commits it to the “hypostatic abstraction,” to a logical and semantic process at the heart of medical practice and which can be encapsulated in the idea that doctors treat “things”

that people “have.” Psychiatry is, therefore, committed to the very idea that the person in the clinical encounter rejects. Mad activism, then, in emphasizing that aspect of the encounter issues a provocation that goes to the heart of psychiatry’s identity as a medical specialty. Before considering possible responses to this challenge (Section IV), I outline the notion of the hypostatic abstraction.

III. THE HYPOSTATIC ABSTRACTION AND MEDICAL PRACTICE

Abstraction is “the process of considering something independently of its associations or attributes.”⁷ To distinguish a property from its instances is to engage in abstraction such as in the following propositions: the ball is round, honey is sweet, Ahmad is brave. The philosopher Charles Peirce refers to this as precise abstraction, which refers to the act of making precise.⁸ He distinguishes precise abstraction from hypostatic abstraction where the predicate in these sentences—that is, is round, is sweet, is brave—is transformed into a relation between two subjects: instead of honey *is* sweet we say honey *possesses* sweetness; instead of the man *is* shy we say the man *is affected* with shyness. The term “hypostasis” refers to “an underlying reality,” to the “substance or essential nature of an individual.”⁹ A hypostatic abstraction, therefore, is an abstraction from what is considered part of an entity’s essential nature, and now thought of alongside that entity as a separate subject. This process then allows that subject—that is, sweetness, shyness—to feature in its own right in propositions and judgments:

That wonderful operation of hypostatic abstraction by which we seem to create *entia rationis* [objects of thought] that are, nevertheless, sometimes real, furnishes us the means of turning predicates from being signs that we think or think *through*, into being subjects thought of. (Peirce, 1958, paragraph 549 of vol. 4)

The distinction between precise abstraction and hypostatic abstraction is a logical and a semantic distinction, not an ontological one; by effecting a hypostatic abstraction, we create an object of thought, and Peirce is careful to point out that this object is only *sometimes* real. What value is there to be derived from the hypostatic abstraction? By inviting us to conceive, in thought, of the ball and roundness, or of Ahmad and shyness, as two separate subjects, the hypostatic abstraction permits two affordances: *first*, it allows us to ask whether the first subject can be preserved analytically or empirically independently of the second subject—that is, it allows us to interrogate essentiality; *second*, the reification afforded by the hypostatic abstraction allows the abstracted property to feature in judgments independently of the first subject.¹⁰

Applied to medicine, the hypostatic abstraction allows us to talk of conditions, disorders, and diseases—of “things” a person “has.” It then allows us

to interrogate whether those “things” belong to the person’s essential nature (the first affordance noted above).¹¹ Clinical diagnosis is a form of hypostatic abstraction; it transforms a suffering human being into a human being plus suffering. Instead of saying Mahmoud is depressed, we say Mahmoud is affected with depression; instead of saying Lisandra is schizophrenic, we say Lisandra is affected with schizophrenia.¹² Medicine operates in the logical and semantic space made possible by the hypostatic abstraction. With the question of essentiality now posed, the clinical encounter—typically and initially—assumes that the condition *is not* part of the person’s essential nature. The aim, at this early stage, is to return the person to the state he was in prior to the onset of the condition. This requires that the condition is distinguished from the person’s pre-condition state, for otherwise that state cannot be recovered. Here, the hypostatic abstraction is central to the promise and the hope that are a feature of many clinical encounters. A typical scenario goes like this: You go to the doctor following experiences of distress (e.g., painful limb, emotional states) and/or disability (e.g., impediments to daily functioning) that you deem to be of a medical nature. The doctor takes a history, examines you, and carries out some investigations. At that point she may offer a diagnosis, inform you about the condition that you have, the treatment regimen you need to follow, and the prognosis you can expect. Implicit in this interaction is the doctor’s promise and the patient’s hope that both will work together to bring the patient back to the state he or she was in prior to the condition, if possible.

As doctors and patients know, promises and hopes of this kind are frequently shattered in medicine. Perhaps the condition is difficult to treat and the person’s pre-condition state is under threat of being lost forever; perhaps the condition is chronic and the person has to learn to live with it. In such cases, the hypostatic abstraction is not necessarily abandoned—we still talk about a person affected with cancer and another affected with chronic pain. And sufferers, in some contexts, talk about “fighting” cancer and “triumphing” over chronic pain, attitudes that indicate a separation between the condition and the person, and an ongoing attempt to imagine oneself without cancer and without pain. There could also come a point where the consensus is that the person will never get better, that their condition is terminal, upon which palliation becomes necessary. At that point, there is acknowledgment that the person’s pre-condition state is unrecoverable; in terminal illness, the promise and hope that ordinarily infuse the clinical encounter are gone, and the hypostatic abstraction is no longer necessary.

Moving on to the second affordance noted above, the hypostatic abstraction allows patient and doctor to hold a unique moral attitude toward the problem as something to be treated and cured. This, in turn, allows the doctor to hold a particular attitude toward the patient. With the condition now conceived of as separate from the person, he or she can inhabit the sick role, and efforts can be directed at treating the condition

without the distraction of moral judgment. The hypostatic abstraction diverts judgment from the person and onto the condition; the person is not “disagreeable,” it is the illness that is “terrible.” Modern medicine does not see itself involved in moral judgment of people’s character. When a person is diagnosed with schizophrenia, that does not make him weak or sinful—schizophrenia is not seen as a character fault: it is an illness.¹³ Of course, people are sometimes blamed for the lifestyle that led to the illness—alcoholism and liver cirrhosis is an example—but once they have the illness, the illness itself can be the target of disapprobation and not the person.

In summary, the two affordances of the hypostatic abstraction are as follows: (1) separating the condition from the person’s pre-condition state in order that the latter can be recovered (at least until it is evident that it cannot be recovered) and (2) diverting moral judgment away from the person and onto the illness.

As I stated toward the end of Section II, the hypostatic abstraction is central to psychiatry’s identity, at the institutional level, as a medical specialty that treats conditions, disorders, or diseases that afflict persons.¹⁴ Accordingly, psychiatry benefits from the aforementioned affordances, and in virtue of them is able to distinguish itself from other approaches to human suffering. To demonstrate this, consider the contrast of the hypostatic abstraction, which is a precise abstraction; that is, propositions that consist in a subject and a predicate instead of a relation between two subjects. Instead of x [has/possesses/is affected by] y , we go back to x is y . To affirm that x is y is to affirm an identity—a self-relation instead of a relation between two subjects. When my suffering is related to my y -ness, the person seeking to help me will seek to work on my y -ness, which is to work on my identity. Because I am, in part, defined by y , any judgment that y incurs is also a judgment that I incur. Accordingly, we lose the protection from moral judgment that was (potentially) afforded by the hypostatic abstraction: if y is bad or good, then so am I. Precise abstraction characterizes certain non-medical approaches to human suffering. For example, in some religious traditions, symptoms of depression and anxiety are understood to be the psychological attributes of a self that had deviated from the proper path of spiritual development (see [Rashed, 2015](#)). These symptoms could then be further understood as indicating the need for spiritual renewal. In such cases, the person is not considered to be affected by these symptoms in a way that leaves his identity untouched, but to be defined by them. Apprehended through a precise abstraction, the depressed person becomes liable to moral judgment in virtue of being depressed. By contrast, the hypostatic abstraction enables psychiatry to distinguish itself from such approaches to human suffering. I would go further and state that one cannot make sense of the distinctive approach of psychiatry if the hypostatic abstraction is omitted from the description of that approach.

While psychiatry's commitment to the hypostatic abstraction opens it up to potentially useful affordances, it closes off the possibility of a different sort of language. When we apprehend a person's suffering through a precise abstraction, the language of identity-making, self-creation, and of good and bad ways of life becomes available to us. While such normative notions can be problematic if they are employed uncritically to pass judgment on other people's lives, they can provide people with the resources to understand their suffering and their experiences in a richer, more personal, and more fulfilling way than is possible through the linguistic affordances of the hypostatic abstraction. But I am running ahead of the purpose of this section, which is to outline the hypostatic abstraction, and to show that it is central to psychiatry's identity at the institutional level.

Before continuing, it is important to distinguish psychiatry's identity at the institutional level from the understanding that some psychiatrists have of what they do on a day-to-day basis. They could point out that the hypostatic abstraction is not central to their work, and that they do not posit the problem as a "condition" connected to, but distinguishable from, the person. They could argue that what they do is help persons cope with distressing experiences and regain their independence and social engagement. They could add that while they might offer a diagnosis for insurance and other bureaucratic purposes, in practice they do not labor under a diagnostic understanding, nor do they suggest one to the person. These are important efforts and, indeed, they seem to offer a (potentially) accommodating response to the challenge of Mad activism. But they do raise a host of questions: if the aforementioned psychiatrists do not labor under a diagnostic understanding, what understanding do they seek in the clinical encounter? How do they frame the encounter now that they have abandoned the hypostatic abstraction? What sort of alternative language do they employ? And what treatment goals do they seek with the person in the clinic? Now, it could be proposed that the answers to these questions will be individual, because they depend on the wisdom and experience of each psychiatrist. Of course, that will not do. For we cannot base a professional practice on such arbitrary standards, nor can we rest content with luck playing such a huge role in determining whom the person will see in the clinic. If individual psychiatrists regularly work outside the space of the hypostatic abstraction—which some Mad activists might welcome—then the concepts that underpin their work need to be explicitly specified—which some Mad activists might demand. Accordingly, we are still confronted by the challenge of Mad activism.

IV. RESPONDING TO THE CHALLENGE OF MAD ACTIVISM

What conceptual resources would enable the clinical encounter to proceed without requiring the hypostatic abstraction and, in this way, to

accommodate the challenge of Mad activism? That is the task we need to consider, but first let me state a response that tries to shy away from this task.

Psychiatry can respond by limiting the cohort of individuals under its purview to those who consider themselves to have a condition, that is, to those who effect a hypostatic abstraction on themselves and frame their experiences and situation in medical terms. This might seem like an obvious response: if I do not consider myself to have a mental health problem, then a psychiatrist is in no position to see me. But it is also an unrealistic response. The fact that a person rejects the hypostatic abstraction does not mean that he or she might not benefit from support to understand and manage experiences that are often challenging. Furthermore, under current arrangements in many countries around the world, people in distress, including many who do not effect on themselves a hypostatic abstraction, often end up before a psychiatric setting. Until existing arrangements are radically different from what they are, psychiatrists will continue to have a major role to play in the assessment and care of mental difference, distress, and disability. Accordingly, it is important to develop the conceptual resources by which clinicians can offer appropriate care to the people they see, including those who do not consider themselves to have a condition.

The ideal response is for psychiatry to develop into a discipline that is able to work with individuals who regard their experiences as part of their identity, as well as those who consider themselves to have a condition. This response can address the shortcomings of the aforementioned one. It allows psychiatry to maintain its identity as a medical specialty, and it renders explicit that psychiatrists need to develop an additional conception of what they are doing that would enable them to satisfactorily respond to the persons they see who reject the hypostatic abstraction. In order to unpack what this conception is, I return to the moment of the clinical encounter, because it is in that moment that the challenge of Mad activism is clearly demonstrated.

Every clinical encounter is framed by two basic issues:

- For what kind of *understanding* of the situation should the clinical encounter aim?
- What is the *therapeutic aim* of the encounter as a whole?

The answers to these questions determine how the encounter will proceed. Typically, they are not addressed at the end of the interaction, but before it begins, and the answers will vary with whether one is seeing a psychiatrist or, say, a psychoanalytic psychotherapist or an occupational therapist. Often, the psychiatrist and the person will disagree on the answers to these two questions, which can hinder the therapeutic process or be taken as a justification for coercive interventions. As many clinicians would recognize, common answers to these questions are as follows: In terms

of understanding, the psychiatrist encourages the person to attain insight, which amounts to being able to recognize that he is exhibiting the symptoms of a “mental disorder.” In terms of therapeutic aim, the most general one is symptom control in order to reduce distress, harm, and disability. Now these are not the only possible answers, and in what follows I examine other possibilities guided by the following: Can the clinical encounter be framed in such a way that allows the ideal response outlined above? I address the two questions in turn.

V. FOR WHAT KIND OF UNDERSTANDING OF THE SITUATION SHOULD THE CLINICAL ENCOUNTER AIM?

For a psychiatrist seeing a prospective patient and contemplating the syndrome or syndromes that best describe his subjective reports and behavior, one can forget that much had occurred for this meeting to happen. As Derek Bolton writes:

The pathway leading to diagnosis of a mental disorder in a person includes at least the following three crucial steps: first, someone (often though not necessarily the person himself or herself) coming to the belief that the person has a problem, that their mental state and behaviour is in some way problematic; second, construal of the problem as being a mental health problem, or mental disorder (as opposed to being, for example, part of life's troubles, or a spiritual problem); and third, classification of the mental health problem as being of a particular kind, such as major depression, schizophrenia, or borderline personality. (2010, 328–29)

For the third step (the clinical encounter) to be possible, steps one and two need to go a certain way, and they could go otherwise. With regard to step one, it may be judged that the problems in mental state and behavior that have been identified are not individual problems but are a result of a mismatch between dominant cultural norms and the norms of a subcultural group to which the person belongs. An example could be a person who is considered to be unwell for expressing beliefs and engaging in ritualistic behaviors that are otherwise normal in his community.¹⁵ Assuming that the problems identified in step one are not due to a mismatch, the process leading to the clinical encounter can still be stopped at step two, if the person and/or the community understand these problems in, say, religious or spiritual terms. When the first two steps go a certain way and we arrive at step three, the scope of understanding the problems is more circumscribed. At that stage, there are two main issues to consider:

- (1) *Clarify the challenges that led to the encounter.* Are the persons experiencing significant distress and disability? Are they unable to keep up with their personal expectations and social duties? Is there a risk of

personal harm or harm to others? Is it a family member or someone in the community who has expressed worries about those persons?

- (2) *Clarify the range of cognitive, emotional, and psychological issues that are present.* These issues are considered to be related to the challenges identified in (1), as somehow being at the root of these challenges or, at least, as playing some role in their genesis.

A key task for the clinical encounter is to make the case whereby modifications in (2) can lead to a reduction in the challenges identified in (1). There is, however, a more basic issue that needs to be considered: for whom are the challenges identified in (1) challenges: the person or others? If they are challenges for the person, then the link between (2) and (1) is relatively straightforward. Consider a typical example: A man experiences problems with concentration at work and his performance begins to suffer. He feels tired most of the time, with a low mood, and has not been able to enjoy activities. On many mornings he lacks the motivation to get out of bed. He has been calling off-sick with increasing frequency and his position at work is becoming untenable. He suspects that his experiences might be mental health related and visits a psychiatrist. The psychiatrist offers a diagnosis of Moderate Depressive Episode, and a link is drawn between the problems the young man has been having at work and his mental states.¹⁶ He is offered a sick note to allow him time to recover and is prescribed treatment. Given the three stages leading to the clinical encounter identified earlier, this man arrives at stage three having already begun to understand the challenges as being “mental health related.” The psychiatrist, in stage three, offers confirmation (or disconfirmation) of this understanding and provides a range of treatments and information on prognosis.

A different scenario occurs when the relevant judgments in the first two stages leading to the clinical encounter are made by someone else, not by the person. As I noted in Section II, this scenario is quite common, and many individuals who end up before psychiatry, end up in this way: a family member, a member of the public, a general practitioner, or a social worker raises concerns about a person’s mental states or behavior, concerns deemed to be mental health related. A typical example is a person who holds bizarre or persecutory beliefs, and who begins to profess his beliefs to other people, trying with insistence to convert them to his point of view. This leads to altercations and, ultimately, to police involvement and a mental health assessment. Another example is a person who hears voices and experiences passivity phenomena, and who appears confused in public places, raising concerns about her safety. In such cases, the path to the clinical encounter is determined by *other people* taking issue with the person’s behavior and mental states.

Depending on the healthcare system in place, that person, either voluntarily or involuntarily, is assessed by a mental health practitioner.¹⁷ The

person, therefore, arrives at the third stage (the clinic) without perceiving himself to have mental health related issues. Naturally, such an encounter faces complications of a different sort to the scenario discussed previously, where the person already understands the challenges he faces in mental health terms. One key issue concerns the stance the clinician should take toward the source of the challenges. Should she go along with others and elect the person as the source of these challenges? Or should she go along with the person in seeing that it is not the person himself but other people's reactions to his mental states and behavior that are the problem?¹⁸ Each stance allows a different sort of understanding, or insight, to be cultivated in the clinical encounter between the psychiatrist and the person. The first stance lends itself to primary (or illness) insight, and the second stance lends itself to secondary (or social) insight.¹⁹ Which stance (and form of insight) can accommodate the challenge of Mad activism (by not requiring the hypostatic abstraction)?

Primary (or illness) insight

As stated earlier, many people who end up before psychiatry do not perceive themselves to have a mental health condition. The psychiatrist, on the other hand, is in a position to offer a diagnosis. In this scenario, the person is elected as the source of the challenges that led to the clinical encounter. Accordingly, the kind of understanding, or insight, that is cultivated in the clinical encounter centers around the nature of the problem and its management. Given the expertise of psychiatrists, the patient can be provided with an understanding of the symptoms (e.g., delusions, hallucinations, and passivity phenomena), as well as diagnostic understanding and accompanying psychological and psychobiological theory. The patient's refusal to accept such a set of understandings is reformulated by the psychiatrist as lack of insight. Insight, in the psychiatric context, is defined broadly as "awareness of having a mental disorder, of its symptoms and of its implications" (Lincoln, Lullmann, and Rief, 2007, 1). The kind of understanding advocated by the psychiatrist, therefore, requires the hypostatic abstraction; it requires the patient to accept that he has a condition.

The clinical assertion that the "patient lacks insight" amounts to saying that the person is refusing to attend to his experiences through the hypostatic abstraction. The person is refusing to go along with the psychiatrist and accept that both are tackling the same thing—the "disorder." He does not consider himself to be affected by a condition, rather his experience of and interaction with the world is not for him something separate from whom he is. On the other hand, the psychiatrist is asking him to adopt a stance whereby he is affected by a condition, and then to evaluate negatively that thing with which he is affected. These, of course, are demanding requirements, and one could argue that it is

not reasonable to expect a person to go along with such a radical re-orientation toward his experiences. As clinical experience shows, insight in this sense is often hard to achieve in clinical contexts and, when achieved, occurs at the end of a protracted process that frequently involves coercive treatment and daily exposure to psychiatric and clinical-psychological language.

What we have then is a situation where the hope and the promise that are a feature of a typical clinical encounter, and which I noted in Section III, no longer coincide: The psychiatrist is still offering the promise that she will try to return the patient to the state he was in prior to the condition (by controlling the symptoms of the illness). But this promise is not reciprocated by the person's hope, for whatever that hope is, it is not to be cured of who he is (even if he wants, or would benefit from, guidance to understand what he is going through). The person thus rejects the kind of understanding put forward by the clinician. It is evident that a clinical encounter framed solely by primary (or illness) insight as the goal of shared understanding requires the hypostatic abstraction; accordingly, this notion of insight cannot play a role in responding to the challenge of Mad activism. We can now explore the second stance noted earlier, and a possible understanding of that to which it lends itself.

Secondary (or social) insight

Another stance to adopt toward those who do not regard themselves to have a mental health condition is to consider, along with the person, that other people's reactions to his mental states and behavior are the source of the challenges that led to the clinical encounter. This stance can then allow the person and the psychiatrist to think about these reactions and to make them the focus of understanding. Given that the person's mental states and behavior are no longer the primary focus, we can qualify this kind of insight as "secondary" insight. It can also be called "social" insight, since by foregrounding the social manifestations of one's mental states and behavior, one can develop a more complex understanding of surrounding norms and expectations (without having to agree with them). Furthermore, this kind of insight, unlike primary insight, does not require the hypostatic abstraction, and therefore it can be an adequate aim for a clinical encounter that seeks to accommodate the challenge of Mad activism. What are the features of secondary insight?

The term "secondary insight," in the sense used here, appears sparingly in the literature. It is used in passing by Jackson and Fulford in the context of thinking about the case studies of three individuals:

All three subjects . . . exhibited a kind of "secondary insight" towards their experiences, in the sense that they recognized that others might see them as being bizarre or mad. They were appropriately selective about whom they confided in,

and had not previously described their experiences in such detail before the interviews. (1997, 48–49)

Elsewhere, I have defined secondary insight as follows:

The subject's ability to take an observer view of herself and to appreciate that she might have deviated from consensual opinion in what she is asserting. In working with the patient toward secondary insight, we develop, with the patient, an understanding of why other people (the relevant [sub] cultural group) might find her experiences and the language she uses to talk about them unusual or bizarre (Rashed, 2010, 203).

Secondary insight is a kind of understanding where the person endeavors to see herself from the point of view of social norms and values she might not subscribe to or agree with but can recognize as possessing some wider consensus. These norms and values inform the social reaction to her mental states and behavior, the reaction that led to the clinical encounter.

Like primary (or illness) insight, secondary insight involves mediation, by which I mean the placement of one's mental states and behavior in relation to something else outside of them. Mediation is not optional: the clinical encounter must aim toward a constructive understanding of the situation. This understanding provides the conceptual and practical framework for intervening in the problems that led to the encounter. With primary insight, that framework includes diagnostic constructs and associated psychobiological theory. It allows for individual interventions that can be medical, psychological, and/or social in nature. With secondary insight, the person is also asked to think outside of himself, yet here he is required to consider himself in light of his understanding of the relevant social contexts. By aiming for secondary insight, a person's understanding of the social effects and implications of her beliefs and behaviors are considered more relevant than her understanding of psychobiological theory or diagnostic classifications. If mediation is required for intervention to be possible, what kinds of interventions are suggested by secondary (or social) insight?

A focus on secondary insight opens the door for interventions geared toward conflict-resolution. Secondary insight allows for interrogation of the circumstances that led to the clinical encounter. Questions such as the following are relevant: How did the conflict/problems between the person and others begin, and how did this lead to the clinical encounter? What norms have been violated? Whose norms are these? Can these problems be prevented from happening again? What do the various parties need to do toward a solution? In asking these questions, all relevant parties fall into view and, where possible, ought to be involved not merely in order to offer a collateral history, but as direct parties in the negotiation and potential resolution of the problems.

On the individual level, a focus on secondary insight allows the person to understand that certain behaviors are likely to result in the kinds of conflicts

that would lead to the clinical encounter. For example, if I believe with conviction that there is a systematic conspiracy by government agencies to achieve an end, and if I spend my time trying to convince others of my point of view, I may benefit from understanding that such interventions are likely to end in conflict. Developing secondary insight can help reduce the incidence of such problems by enabling me to be more discerning in whom I discuss my convictions with. Now this might seem like an attempt by the psychiatrist to enforce norms of conduct on the person, but in fact it is not so. The norms in question already exist in the community—one could argue that they are problematic norms and ought to change to accommodate a broader range of mental and behavioral difference, perhaps in line with the social model of disability (see [Rashed, 2019a](#)). However, that kind of change is a social, political, and cultural matter, and not something that can be actioned in the clinic; it requires collective activism and community organizing. On the other hand, the role of the psychiatrist *insofar as the clinical encounter is concerned* is to assist the person she is seeing in the clinic, and interventions that require collective social change are outside her control.²⁰ By alerting the person to the realities of existing norms and to the implications of his behavior, she provides him with opportunities to develop social insight and through that to have more control over his situation. This can reduce opportunities for conflict, which in turn can reduce the number of unwanted admissions to mental health units. In summary, like primary insight, secondary insight involves mediation and provides a conceptual and practical framework that can bring benefits to the person.

Crucially, for our purposes here, the concept of secondary insight does not require the hypostatic abstraction and focuses instead on the social and interpersonal conflicts that led to the encounter. Accordingly, the answer to the question that led us here—for what kind of understanding of the situation should the clinical encounter aim if it is to satisfy the challenge of Mad activism?—is that the encounter should aim for secondary (or social) insight.

VI. WHAT IS THE THERAPEUTIC AIM OF THE ENCOUNTER AS A WHOLE?

Toward the end of Section IV, I identified two issues that frame the clinical encounter: the kind of *understanding* for which the encounter should aim, and its *therapeutic aim*. We can now examine the latter issue. The aim of a typical clinical encounter is symptom control in order to reduce distress, harm, and disability. Such an aim is consistent with primary (or illness) insight, for once we understand the challenges that led to the clinical encounter to be a direct result of the range of cognitive, emotional, and psychological issues that are present (the “symptoms”), controlling these symptoms presents itself as an obvious therapeutic aim. In contrast to primary insight,

secondary insight focuses on the sources of social disagreement and elects the response of others to the person's mental states and behavior as the source of the challenges that led to the clinical encounter. Accordingly, it would seem, an encounter that takes secondary insight as the aim of understanding has nothing to say to the range of cognitive, emotional, and psychological issues that are present, except to acknowledge their social impact. In what follows, I want to argue that this does not have to be the case and that an encounter framed by secondary insight can still attend therapeutically to the person's mental life *without falling back on the hypostatic abstraction*. In fact, the stance of secondary insight is particularly suited for this because it frees the encounter from the language of psychopathology and disorder and allows for exploration of the meaning and significance of the person's experiences and situation. The encounter can then concern itself not solely with symptom control but also with "identity-making."²¹

Identity-making

Why should an encounter framed by secondary insight concern itself in any way with the person's mental life? Recall that we are still considering individuals who do not perceive themselves to have mental health related issues and who arrive at the clinical encounter because of other people's responses to their mental states and behavior. From their point of view, there is nothing "wrong" with them. But, while they might reject the idea that they are "ill," they might be going through challenging experiences and events and might be struggling to make sense of them. They might not wish to understand them as conditions to be managed and cured, but that does not mean that the question of *how* to understand these phenomena is resolved.

It is widely recognized that people experiencing phenomena such as voices, "passivity" experiences, and other changes in the unity and continuity of self, are actively engaged in attempts to make sense of their experiences and incorporate them in their developing identity (their self-understanding) (see, e.g., [Barker, Campbell, and Davidson, 1999](#); [Larsen, 2004](#); [Geekie and Read, 2009](#)). This process is affected by many factors, including the nature and intensity of experiences, available narratives, individual creativity, and the input of family members and experts ([Rashed, 2012](#)). Such attempts are not always successful and can produce narratives that are fragmented or idiosyncratic ("delusional") (see [Phillips, 2003](#), 327–331). With "delusional" narratives, the subject organizes his experience around a systematized core of persecution or exaggerated self-importance. A fragmented narrative, on the other hand, is a failed narrative, a consequence of the subject's inability to transcend intense emotional experiences and cognitive challenges. In many cases, therefore, individuals require support to construct a narrative that can bring a sense of order and meaning to their experiences, while retaining a basis in a shared understanding.

Assisting individuals with constructing an identity is a recognized aim in the literature. In *Towards Humanism in Psychiatry*, Jonathan Glover (2003, 532) writes that one aim of a humanist psychiatry “is to improve people’s damaged or impaired capacity for living a good human life.” Among the many factors that enter into a good life, Glover considers “self-creation” (or identity-making) to be of fundamental importance. Reflecting a similar concern, Jennifer Radden (2003, 359) argues that “some of the task of attributing and constructing self-identity may be one that can be undertaken by others when the patient’s own identity-constructing capabilities are compromised,” a task that can be adopted among the goals of therapy (Radden, 1996, Chapter 13). In his essay *How Do I Learn to Be Me Again?* Grant Gillett (2012, 249) writes that when people are ill, they need a “guide, an informant” who engages them in a “reasoned, respectful discussion . . . that enables [them] to assume and enact identities and to live out life stories each with its unique value.”

Identity-making, as described here, indicates the *what* of the therapeutic aim of the clinical encounter but not the *how*. If we accept identity-making as a valid aim for the encounter, and one that does not require the hypostatic abstraction (satisfying the challenge of Mad activism), how can individuals be supported in achieving this aim?

A key issue to note is the context where individuals will be assisted with the process of identity-making. Glover and Radden suggest endeavors of the kind one would see in clinical practice. Psychiatrists can begin the process by inquiring about a person’s broad understanding of what is happening to her. They can, as Gillett suggests, act as a “guide, an informant” for the persons they see.²² The role of the guide raises its own complexities, for a guide must possess some prior understanding of the situation or, at least, be able to direct the person to those who do. In this context, some mental health groups and networks, including those involved in activism, are of crucial importance. These groups engage in the construction of counter-narratives of psychological, emotional, and behavior diversity.²³ Narratives such as “healing voices,” “dangerous gifts,” and “spiritual emergence” are alternatives to diagnostic language and to clinical-psychological formulation.²⁴ They are intended to capture something fundamental about the meaning and significance of phenomena of madness without, in many cases, requiring the hypostatic abstraction. Psychiatrists can learn about these narratives in order to work with them in the clinical encounter. Ultimately, shared narratives are blueprints that can help a person make sense of her experiences and adopt a broader and unifying perspective on what is happening to her. In being worked out in a group, these narratives are more likely to achieve a degree of social intelligibility and can play a role in tempering the excesses and idiosyncrasies of the subjective narratives with which the person might initially present. Additionally, psychiatrists can learn about the various mental health networks and encourage the persons they see to engage with appropriate ones. Networks such as the Hearing Voices Movement (Longden,

Corstens, and Dillon, 2013), Open Dialogue and Soteria (Thomas, 2013), and the Icarus Project (DuBrul, 2014) are avenues where people can get together and develop a shared understanding of their experiences; in such cases, people can act as guides and informants to each other.

So far in the discussion, the assumption has been of an individual who (1) rejects the hypostatic abstraction and (2) is able to work toward secondary insight and identity-making. That second assumption, as many clinicians would recognize, is one that cannot always be made. A person with severe thought disorder can struggle to communicate; another person's sense of self can be fragmented to the point where the question of identity cannot be raised; and another can experience social withdrawal and persecutory fears sufficient to prevent interaction with others. This is to be contrasted with those who experience unusual phenomena (such as "passivity" phenomena and voices) but are able to interact socially, partake fruitfully in the clinical encounter, join groups, and develop with others a shared understanding of their experiences. For those who are not (yet) able to engage in identity-making, the kind of support they need is not to author an identity but to regain basic cognitive and psychological functions. All of this is true, but the fact that some people have severe communication and interpersonal difficulties owing to particular psychological, emotional, and cognitive challenges does not have to undermine the new ways for thinking about the clinical encounter for which I have been arguing in this paper. We must not define the entire mental health field by either extreme end of functional ability, neither by those who are mad and "ill" nor by those who are mad and "well." People who are "ill" can get "better" and be able to engage with the clinical encounter. This raises questions concerning the kind of care they need to be able to get to this point, and how it can be delivered respectfully, safely, and ethically. These questions recall ongoing concerns in psychiatric ethics, problems often discussed under mental capacity, harm to self and others, and the justifications for involuntary treatment. Rethinking the clinical encounter in terms of secondary insight and identity-making is not going to make these questions disappear but can provide an opportunity to consider them in a new light.

VII. CONCLUSIONS

The identity of psychiatry as a medical speciality has often been challenged. Among the challenges noted in the introduction, this paper focused on Mad activism. Some activists reject a core principle underlying medical theory and practice, a principle based on a hypostatic abstraction: doctors treat conditions, disorders, or diseases; they treat "things" that people "have." In order for psychiatry to accommodate the challenge of Mad activism, it needs to develop into a discipline that is open to working in the clinical encounter both with primary (or illness) insight in cases where persons effect a hypostatic

abstraction on themselves, as well as with secondary (or social) insight in cases where persons reject the hypostatic abstraction. While primary insight lends itself to a range of psychological and medical interventions, secondary insight allows for interventions that can help reduce opportunities for social conflict and, therefore, reduce unwanted admissions to mental health units. Additionally, a clinical encounter framed by secondary insight as the aim of understanding can adopt identity-making as a therapeutic goal without requiring the hypostatic abstraction. Many people who present before psychiatry are concerned with making sense of experiences that are often challenging and defy easy understanding. By working toward identity-making, psychiatrists can assist these individuals without the assumption that they have a condition to be managed or cured.

The challenge of Mad activism provides an opportunity to rethink the basic framing of the clinical encounter. I have argued that secondary insight and identity-making are key concepts that can be explicitly adopted alongside primary insight and symptom control. But to rethink the clinical encounter is not, yet, to rethink the entirety of mental health practice. There are several questions on which I have not touched or only minimally so. For example, what role do diagnostic practices have, if any, in encounters framed by secondary insight and identity-making? What should happen with persons who appear to lack capacity for certain decisions and who present a risk to themselves or to others? What role is there for symptom control alongside identity-making, and what ethical problems does this raise? What sort of additional training do clinicians need in order to be able to work with the concepts suggested here? All of these are important questions, but we can now reconsider them in light of the concepts advanced in this paper, and in the context of a clinical encounter that endeavors to accommodate the challenge of Mad activism.

ACKNOWLEDGMENTS

Many thanks to Professor Warren Kinghorn for his patience and guidance throughout the process of writing this article and preparing it for publication. I began thinking about the concept of 'secondary insight' back in 2009. At the time, I developed the concept with Dr Rachel Bingham, and a year later we presented "An Observer's View of Oneself: Secondary Insight as a Negotiating Tool in Psychiatry" at the Conference of the International Network of Philosophy and Psychiatry (Manchester, 2010). During the summer of 2019, I organized two workshops at Birkbeck College, University of London, on "Mental Health Activism and Clinical Practice". I am grateful to the attendees for their participation and inspiration. Finally, thank you to the Wellcome Trust for providing Open Access fees for this article.

NOTES

1. Disclosure: in this paper, reflections on the clinical encounter and on medical education and practice arise, in part, from my observations and experiences over the past 25 years, first as a medical student and junior doctor at Cairo University Medical School and Hospitals, then as an orthopedic surgeon

in the north of England and, subsequently, as a psychiatrist in several community clinics, hospitals, and prisons in London. After practicing psychiatry for several years, I moved on to full-time research and teaching in philosophy and psychiatry.

2. With regard to the normative complexity of psychiatry, debates revolve around the definition of the concept of mental disorder, and the role of values versus facts in defining the boundaries of illness (see, e.g., Boorse, 2011; Bolton, 2008, 2013b; Bolton and Banner, 2012). Debates on the explanatory complexity of psychiatry center around the role of, and interaction among, biological and psychosocial factors in the explanation of disorder (Bolton, 2013a, 25; Hernandez and Blazer, 2006; Baker and Menken, 2001; Huda, 2019). Connected to this, a question that is often raised is whether mental disorders can be considered as brain disorders (White, Rickards, and Zeman, 2012). With regard to classificatory complexity, the issues center on the nature of mental disorders and the validity of existing classifications (Kinderman et al., 2013; Horwitz and Wakefield, 2007). Often, the problem is framed by asking whether mental disorders are natural kinds (Jablensky, 2016; Kendell and Jablensky, 2003; Zachar, 2015; Haslam, 2002; Cooper, 2013; Simon, 2011).

3. The four challenges identified in the text are not the only ones. The following is a nonexhaustive list of some additional problems. There are well-known difficulties and controversies surrounding the efficacy and risks of antidepressant and antipsychotic medication (see, e.g., Moncrieff, 2013); ethical concerns surrounding the treatment of depression (see, e.g., Hoffman, 2013); distinctive ethical complexities arising from the fact that mental health patients can be particularly vulnerable, raising questions of capacity not ordinarily raised in other medical specialties (see, e.g., Radden and Sadler, 2010); and complexities surrounding the metaphysics of psychiatry (see, e.g., Zachar, 2014; Maiese, 2016).

4. For the history of mental health activism, consult Crossley (2006) and Rashed (2019b, Chapter 1). The website of the Survivors' History Group is an invaluable resource: <http://studymore.org.uk/mpu.htm>.

5. For accounts of Mad Pride and mad-positive activism, consult Curtis et al. (2000), Finkler (1997), Reaume (2008), Sen (2011), Triest (2012), Costa (2015), Clare (2011), Polvora (2011), and deBie (2013). See Hoffman (2019) for some distinctions among different types of Mad Pride activism.

6. In this article, I do not consider issues of risk to self and/or others, nor do I consider questions of involuntary treatment and when it is justified. What I am concerned with is a more basic framing issue that could change how the clinical encounter is conducted and how risk is appraised and managed. Please see the Conclusion section for suggestions for further work.

7. Oxford English Dictionary (online: <https://en.oxforddictionaries.com/definition/abstraction>).

8. See Peirce (1958, paragraph 235 of volume 4, and paragraph 534 of volume 5).

9. Oxford English Dictionary (online: <https://en.oxforddictionaries.com/definition/hypostasis>) and Merriam-Webster dictionary (online: <https://www.merriam-webster.com/dictionary/hypostasis>).

10. When we transform the proposition "Ahmad is shy" to "Ahmad is affected with shyness," we can then ask whether shyness is an essential property of Ahmad or a temporary association that can be distinguished from his more enduring properties.

11. A property is essential to the extent that the object in question would cease to be what it is in the absence of this property. For example, it is an essential property of a planet that it orbits around a star. For the purpose of this article, it is sufficient that a property is taken to be (or not taken to be) an aspect of a person's essential nature. I am not concerned with the actual ontological status of such a determination, only with its pragmatic aspects. (For further discussion, see Rashed and Bingham, 2014, 246–249.)

12. Zachar and Kendler (2007, 559) refer to a similar view when they make the distinction between entities and agents. The entity perspective of psychiatric disorders views "individuals as *vehicles* for pathological syndromes" (recalling the hypostatic abstraction), while the agent perspective attempts "to focus on persons more than on patients." However, beyond making the distinction, the authors do not subject it to further exploration.

13. The fundamental intuition underlying illness attributions is that persons are unable to do what they want to do or to meet social expectations, "not because they are naughty, lazy, rude, bad, weak-willed, or insincere—but because they are ill" (Bolton, 2013b, 445). Illness, on this view, is a form of incapacity that the person cannot help and hence is not to be condemned for.

14. Note that the hypostatic abstraction is not synonymous with mental disorder diagnoses, even if such diagnoses are exemplary exemplars of it. We can "drop the language of disorder," as some are advocating (Kinderman et al., 2013), while still regarding the phenomena in question as something the person has or possesses rather than as attributes of the person. It is also not synonymous with a particular account of causation. To say that Lisandra is affected with schizophrenia is to leave open the question

as to why she is affected, and the answer can include relevant causal factors of a social, psychological, and biological nature. And neither is it synonymous with the concept of illness. If we understand illness as a form of incapacity that the person cannot help and, hence, is not to be condemned for, then this incapacity can be hypostatically abstracted or not. Finally, the hypostatic abstraction is not synonymous with the cultural framework of modern medicine and clinical psychology. In fact, it does not matter what the cultural framework is. For example, healers who work within the framework of spirit possession are performing a hypostatic abstraction by attributing aspects of the person's traits and behaviors to a "spirit" (in medicine this attribution is made to the "condition") (see [Rashed, 2018](#)).

15. I address this problem under a discussion of the concept of cultural congruence as applied to psychiatric diagnosis ([Rashed, 2013](#)).

16. Note that this stance is consistent with a range of causal explanations. I could formulate the cause of my depressed mood to be long-term psychoactive drug use, or the result of the cumulative effects of poverty, or the outcome of an unhealthy perfectionism, or the absence of social support at a difficult time, and so on. However, the issue with which I am concerned here is not the casual explanation of the mental states in question, but their relation to the personal and/or social problems that have led to the clinical encounter.

17. Voluntarily, people might agree to attend the assessment for a number of reasons, despite not considering themselves to have a mental disorder. They might do so to assuage the worries of a family member or to prove them wrong. Or they might have other issues they want medical support with, such as insomnia or anxiety. Or they might have challenging experiences and want to discuss this with a mental health professional.

18. Note that these two stances are not mutually exclusive; you can hold different stances toward different problems.

19. It is evident that each stance maps onto a medical model of disability versus a social model of disability framework: if I think other people are the problem, then what needs to happen is for other people to change in order to accommodate my behavior. At this stage, however, I am not concerned with interventions, but with the kind of understanding that can be the aim of the clinical encounter.

20. Doctors, including psychiatrists, can, of course, be agents for social change. They can lobby the government, engage in activism and community organizing, and, in general, attempt to realize their political values in the sphere of healthcare provision. All of this occurs outside the clinic: the clinic cannot be the site where doctors prioritize their political agendas because this can conflict with the patient's. It can place the patient in the position of being a means to the doctor's political ends, which is morally problematic. In short, being an agent for social change is not coextensive with—and hence can conflict with—being an agent for the patient's interests.

21. The qualification 'not solely' indicates that identity-making and symptom control are not mutually exclusive goals, as long as 'symptom control' is disentangled from diagnosis and the hypostatic abstraction. A person might reject the hypostatic abstraction (and opt for an alternative understanding of her experiences and situation) and, at the same time, accept/request medication for particular symptoms (to relieve the distress and disability associated with these symptoms). The experience of paranoia, for example, can be uniquely distressing, and medication can help with this. But if that is the case, what sort of justifications are there for a person who does not believe that he has a mental disorder to take medication developed for treating mental disorder? And what is the psychiatrist's position in this situation? In an important paper, [Marga Reimer \(2010\)](#) points to robust empirical evidence that many people take medication despite 'poor' primary (or illness) insight. They do so because, from their point of view, the medication does in fact relieve some distress or solve some problem for them. Reimer argues that the clinician may offer medication to the person on the person's own terms, for example as being for difficulties "articulated by the patient himself" (2010, 72). However, such an attitude does raise ethical worries concerning openness and honesty about the psychiatrist's agenda in the clinical encounter, issues that require separate consideration.

22. Note that identity-making (and secondary [or social] insight) are not all or nothing. One can have more-or-less social insight, and one can be more-or-less able to make sense of experiences and situations.

23. For details on these narratives see [Rashed \(2019b, Chapter 9\)](#), [DuBrul \(2014\)](#), [Clay \(1999\)](#), [Geekie and Read \(2009\)](#), [Peddie \(2014\)](#), [Fletcher \(2017\)](#), [Longden, Corstens, and Dillon \(2013\)](#), and the documentaries *Crooked Beauty* (the third movie in the *Mad Dance Trilogy* directed by Ken Rosenthal, 2010) and *Healing Voices* (directed by P. J. Moynihan, 2016). See also Eleanor Longden's TED TALK: *The Voices in my Head* (2013). Online: https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head/up-next.

24. The narratives identified in the text aim to support people by providing them with the cultural resources to make sense of their experiences. They aim to enhance people's lives within the broader community, and not to bring harm upon them. It is possible, however, for other narratives to encourage ways of life that can bring harm on those who endorse them. Positive narratives surrounding severe "eating disorders" (e.g., Pro Ana communities) could be considered by some people as an example of this, which goes to show that there is a need for adjudicating among various narratives before they can be encouraged. In general, people, clinicians included, cannot be expected to endorse values and beliefs that go against their worldview. But because we are dealing with issues of public interest that affect the lives of millions of people (i.e., cultural understandings of mental health and their implications), we need to provide a reasoned argument for why we are inclined to reject (or indeed accept) a particular narrative and the way of life it supports. Elsewhere (Rashed, 2019b, Chapters 5 and 10), I develop a framework for adjudicating identity-claims. This framework requires that we examine whether a claim is morally objectionable or irrational and whether a positive case can be made for a particular claim in light of the moral and political resources of the theory of recognition.

REFERENCES

- Baker, M., and M. Menken. 2001. Time to abandon the term mental illness. *BMJ* 322(7291):937.
- Barker, P., P. Campbell, and B. Davidson, eds. 1999. *From the Ashes of Experience: Reflections on Madness, Survival, and Growth*. London, United Kingdom: Whurr Publishers.
- Bolton, D. 2008. *What Is Mental Disorder? An Essay in Philosophy, Science and Values*. Oxford, United Kingdom: Oxford University Press.
- . 2010. Conceptualisation of mental disorder and its personal meanings. *Journal of Mental Health* 19(4):328–36.
- . 2013a. Should mental disorder be regarded as brain disorders? 21st century mental health sciences and implications for research and training. *World Psychiatry* 12(1):24–5.
- . 2013b. What is mental illness? In *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler, G. Stanghellini, and T. Thornton, 434–50. Oxford, United Kingdom: Oxford University Press.
- Bolton, D., and N. Banner. 2012. Does mental disorder involve loss of personal autonomy? In *Autonomy and Mental Disorder*, ed. L. Radoilska, 77–99. Oxford, United Kingdom: Oxford University Press.
- Boorse, C. 2011. Concepts of health and disease. In *Philosophy of Medicine*, ed. F. Gifford, 13–64. Amsterdam, The Netherlands: Elsevier.
- Clare. 2011. Mad culture, mad community, mad life. *Asylum* 18(1):15–7.
- Clay, S. 1999. Madness and reality. In *From the Ashes of Experience: Reflections on Madness, Survival, and Growth*, eds. P. Barker, P. Campbell, and B. Davidson, 16–36. London, United Kingdom: Whurr Publishers.
- Cook, H. 2010. Borderlands: A historian's perspective on medical humanities in the US and UK. *Medical Humanities* 36(1):3–4.
- Cooper, R. 2013. Natural kinds. In *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler, G. Stanghellini, and T. Thornton, 950–65. Oxford, United Kingdom: Oxford University Press.
- Costa, L. 2015. *Mad Pride in Our Mad Culture*. Consumer/Survivor Information Resource Centre Bulletin, No. 535 [On-line]. Available: http://www.csinfo.ca/bulletin/Bulletin_535.pdf (accessed March 19, 2020)
- Cox, J., A. Campbell, and K. W. M. Fulford, eds. 2007. *Medicine of the Persons: Faith, Science and Values in Health Care Provision*. London, United Kingdom: Jessica Kingsley Publishers.

- Crossley, N. 2006. *Contesting Psychiatry: Social Movements in Mental Health*. London, United Kingdom: Routledge.
- Curtis, T., R. Dellar, E. Leslie, and B. Watson, eds. 2000. *Mad Pride: A Celebration of Mad Culture*. Truro, England: Chipmunkpublishing.
- deBie, A. 2013. And what is mad pride? Opening speech of the first Mad Pride Hamilton Event on July 27, 2013. *This Insane Life* 1(1):7–8.
- DuBrul, S. 2014. The Icarus Project: A counter narrative for psychic diversity. *Journal of Medical Humanities* 35(3):257–71.
- Finkler, L. 1997. Psychiatric survivor Pride Day: Community organising with psychiatric survivors. *Osgoode Hall Law Journal* 35(3/4):763–72.
- Fletcher, E. 2017. Uncivilizing “mental illness”: Contextualizing diverse mental states and posthuman emotional ecologies within The Icarus Project. *Journal of Medical Humanities* 39(3):29–43.
- Fulford, K., C. W. van Staden, and R. Crisp. 2013. Values-based practice: Topsy-turvy take-home messages from ordinary language philosophy (and a few next steps). In *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler, G. Stanghellini, and T. Thornton, 385–412. Oxford, United Kingdom: Oxford University Press.
- Geekie, J., and J. Read. 2009. *Making Sense of Madness: Contesting the Meaning of Schizophrenia*. London, United Kingdom: Routledge.
- Gillett, G. 2012. How do I learn to be me again? Autonomy, life skills, and identity. In *Autonomy and Mental Disorder*, eds. L. Radoilska, 233–51. Oxford, United Kingdom: Oxford University Press.
- Glover, J. 2003. *Towards Humanism in Psychiatry. The Tanner Lectures on Human Values*. [On-line]. Available: https://tannerlectures.utah.edu/_documents/a-to-z/g/glover_2003.pdf.
- Haslam, N. 2002. Kinds of kinds: A conceptual taxonomy of psychiatric categories. *Philosophy, Psychiatry and Psychology* 9(3):203–17.
- Hernandez, L., and D. Blazer. 2006. *Genes, Behaviour, and the Social Environment: Moving Beyond the Nature/Nurture Debate*. Washington, DC: The National Academics Press.
- Hoffman, G. 2013. Treating yourself as an object: Self-objectification and the ethical dimensions of antidepressant use. *Neuroethics* 6(1):165–78.
- . 2019. Public mental health without the health? Challenges and contributions from the Mad Pride and neurodiversity paradigms. In *Developments in Neuroethics and Bioethics Volume 2: Mental Health as Public Health: Interdisciplinary Perspectives on the Ethics of Prevention*, eds. K. Cratsley and J. Radden, 289–326. London, United Kingdom: Elsevier.
- Horwitz, A., and J. Wakefield. 2007. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford, United Kingdom: Oxford University Press.
- Huda, S. 2019. *The Medical Model in Mental Health: An Explanation and Evaluation*. Oxford, United Kingdom: Oxford University Press.
- Jablensky, A. 2016. Psychiatric classifications: Validity and utility. *World Psychiatry* 15(1):26–31.
- Jackson, M., and K. Fulford. 1997. Spiritual experience and psychopathology. *Philosophy, Psychiatry, and Psychology* 4(1):41–65.
- Kendell, R., and A. Jablensky. 2003. Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry* 160(1):4–12.
- Kinderman, P., J. Read, J. Moncrieff, and R. Bentall. 2013. Drop the language of disorder. *Evidence-Based Mental Health* 16(1):2–3.

- Larsen, J. 2004. Finding meaning in first episode psychosis: Experience, agency and the cultural repertoire. *Medical Anthropology Quarterly* 18(4):447–71.
- Lincoln, T., E. Lullmann, and W. Rief. 2007. Correlates and long-term consequences of poor insight in patients with schizophrenia: A systematic review. *Schizophrenia Bulletin* 33(6):1324–42.
- Longden, E., D. Corstens, and J. Dillon. 2013. Recovery, discovery, and revolution: The work of intervoice and the hearing voices movements. In *Madness Contested: Power and Practice*, eds. S. Coles, S. Keenan, and B. Diamond, 161–80. Herefordshire, United Kingdom: PCCS Books.
- Maiese, M. 2016. *Embodied Selves and Divided Minds*. Oxford, United Kingdom: Oxford University Press.
- McManus, I. 1995. Humanity and the medical humanities. *Lancet* 346(8983):1143–5.
- Moncrieff, J. 2013. *The Bitterest Pills: The Troubling Story of Antipsychotic Drugs*. London, United Kingdom: Palgrave Macmillan.
- Peddie, J. 2014. *Understanding Experience and Constructing Identity in Spiritually Transformative Accounts of Psychosis*. PhD Thesis. University of East London. [On-line] Available: <http://roar.uel.ac.uk/4607/1/James%20Peddie.pdf> (accessed 13 March 2020).
- Peirce, C. 1958. *The Collected Papers of C. S. Peirce*. Vols. 1–8. Cambridge, MA: Harvard University Press.
- Phillips, J. 2003. Self-narrative in schizophrenia. In *The Self in Neuroscience and Psychiatry*, eds. T. Kircher and A. David, 319–35. Cambridge, United Kingdom: Cambridge University Press.
- Polvora. 2011, April 4–5. *Diagnosis “Human.”* Icarus Project Zine [On-line]. Available: <http://www.theicarusproject.net/article/community-zines> (accessed March 13, 2020).
- Radden, J. 1996. *Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality*. Cambridge, MA: MIT Press.
- . 2003. Learning from disunity. *Philosophy, Psychiatry, and Psychology* 10(4):357–9.
- Radden, J., and J. Sadler. 2010. *The Virtuous Psychiatrist: Character Ethics in Psychiatric Practice*. Oxford, United Kingdom: Oxford University Press.
- Rashed, M. A. 2010. Religious experience and psychiatry: Analysis of the conflict and proposal for a way forward. *Philosophy, Psychiatry, and Psychology* 17(3):185–204.
- . 2012. *Subjectivity, Society, and the Experts: Discourses of Madness*. PhD Thesis, University College London.
- . 2013. Culture, salience, and psychiatric diagnosis: Exploring the concept of cultural congruence and its practical application. *Philosophy, Ethics and Humanities in Medicine* 8(5):1–12.
- . 2015. Islamic perspectives on psychiatric ethics. In *The Oxford Handbook of Psychiatric Ethics*, Vol. 1, eds. J. Sadler, C. W. van Staden, and K. W. M. Fulford, 495–519. Oxford, United Kingdom: Oxford University Press.
- . 2018. More things in heaven and earth: Spirit possession, mental disorder, and intentionality. *Journal of Medical Humanities* [On-line]. Available: <https://link.springer.com/content/pdf/10.1007/s10912-018-9519-z.pdf> (accessed April 27, 2020).
- . 2019a. In defense of madness: The problem of disability. *Journal of Medicine and Philosophy* 44(2):150–74.
- . 2019b. *Madness and the Demand for Recognition: A Philosophical Inquiry into Identity and Mental Health Activism*. Oxford, United Kingdom: Oxford University Press.

- Rashed, M. A., and R. Bingham. 2014. Can psychiatry distinguish social deviance from mental disorder? *Philosophy, Psychiatry and Psychology* 21(3):243–55.
- Reaume, G. 2008. A history of Psychiatric Survivor Pride Day during the 1990s. *Consumer/Survivor Information Resource Centre Bulletin* 374(July):2–3.
- Reimer, M. 2010. Treatment adherence in the absence of insight: A puzzle and a proposed solution. *Philosophy, Psychiatry, & Psychology* 17(1):65–75.
- Schrader, S., N. Jones, and M. Shattell. 2013. Mad Pride: Reflections on sociopolitical identity and mental diversity in the context of culturally competent psychiatric care. *Issues in Mental Health Nursing* 34(1):62–4.
- Sen, D. 2011. What is mad culture? *Asylum: The Magazine for Democratic Psychiatry* 18(1):5.
- Simon, J. 2011. Medical ontology. In *Philosophy of Medicine*, ed. F. Gifford, 65–114. Amsterdam, The Netherlands: Elsevier.
- Thomas, P. 2013. Soteria: Contexts, practice, and philosophy. In *Madness Contested: Power and Practice*, eds. S. Coles, S. Keenan, and B. Diamond, 141–58. Herefordshire, United Kingdom: PCCS Books.
- Triest, A. 2012. Mad? There's a movement for that. *Shameless Magazine* 21(1):20–1.
- White, P. D., H. Rickards, and A. Zeman. 2012. Time to end the distinction between mental and neurological illnesses. *BMJ* 344(May):e3454.
- Zachar, P. 2014. *A Metaphysics of Psychopathology*. London, United Kingdom: MIT Press.
- . 2015. Psychiatric disorders: Natural kinds made by the world or practical kinds made by us? *World Psychiatry* 14(3):288–90.
- Zachar, P., and K. Kendler. 2007. Psychiatric disorders: A conceptual taxonomy. *American Journal of Psychiatry* 164(4):557–65.